



Pain & Rehabilitative CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshti, MD | Neil Kamdar, MD | John Alchemy, MD | Filip Cheng, DO
1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:

Supervising: Babak J, Jamasbi, M.D.

Performing: Julia Fellows, PA-C

Encounter Date: Nov 23, 2021

Patient: Shockley, Jonathan (PT00023609)

Sex: Male

DOB: Sep 27, 1978 Age: 43 Year

Race: Unreported/Refused to Report

Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H):
415-312-4029

Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.

Injury Date: 02/15/2019

Employer: Biotelemetry, Inc

Case Insurance: Chubb Son of Federal Ins Company

Claim No.: 040519008736

VISIT TYPE:

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:

Patient is presents via Facetime to follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. He was approved to a consult and met with Dr. Slosar on 2/4/21. He is not currently a surgical candidate for the neck. He currently defers injection therapy as well.

Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied by IMR. He has completed 17/18 sessions of chiropractic therapy with benefit. He notes that these sessions helped to decrease his pain by about 30% and noted some improved tolerance for activity. He would like to continue if possible. He also trialed physical therapy but was only able to complete 1-2 sessions before his pain increased. He has discontinued this.

With regard to medication, he continues with Lidocaine crean, voltaren gel & Flector patches as topical medications. These decrease his pain from 5/10 to 2/10 and prevents flare ups. He denies side effects with his medications. He does request for refills today.

Patient reports seeing his QME in March 2021 and we have this report for review today.

Medical History:

PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY

The patient does not smoke cigarettes.

The patient does not drink alcoholic beverages.

The patient does not use illicit drugs.

The patient is not married.

The patient has a significant other.

The patient has no children.

Patient does not have a family history of childhood abuse.

Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:

*** FAMILY HISTORY

Patient does not have a family history of drug addiction.

Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:

2014 E/M:

Constitutional - General Appearance:

Patient is near ideal body weight and is well groomed..

Orientation:

Patient is alert and oriented x3..

Mood and Affect:

Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:

1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply 2-3 grams to affected area up to 4 times daily update sig
3. Flector 1.3% Patch Apply 1 patch to affected area 12hours on/off
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:

and 6 sessions of Chiropractic Treatment 98941, 97140, G0283, 97012. Neck, bilateral elbows, forearms, wrists and hands.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region

M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:

Refill Added:

1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1

2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 100.00. REF: 1

3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presense of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presense of ulnar neuropathy.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied by IMR. Patient has nearlt completed chiropractic therapy with benefit as described above. We will submit for 6 more today.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural

foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. He met with Dr. Solsar to discuss his neck and upper extremity symptoms. Per this report, Dr. Slosar does not find him to be a surgical candidate as cervical spine surgery will likely not lead to improvement of his upper extremity pain. The patient understands this.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had an abnormal TSH shortly after discontinuing gabapentin and he believes that the medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

-Patient currently defers the Functional Restoration Program.

-Patient saw Dr. Stoller again on 3/11/21 and we finally received this report. Per Dr. Stoller, the patient is permanent and stationary with 20% WPI and permanent disability. He did provision for future medical care as well. As patient currently defers FRP or further invasive care, we agree that he is MMI and have updated this below.

Follow up in 4-6 weeks.

WORK STATUS:

The patient is permanent and stationary per Dr. Stoller QME DOS 3/11/21.

TIME SPENT:

For this visit the total time the provider spent for the encounter is the most appropriate determinate of the level of service. The time reported includes the direct face to face time with patient and the total time spent 20 minutes.

This includes: counseling and educating the patient, family or caregiver, documenting clinical information in the electronic health record ordering medications, tests or procedures To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of

the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2)

because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.

*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where

target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidoderm Patch: The following has been recommended regarding Lidoderm Patch in the MTUS/ACOEM guidelines

Lidocaine Patches for Neuropathic Pain
Moderately Recommended.

Lidocaine patches are moderately recommended for treatment of postherpetic neuralgia when there is localized pain amenable to topical treatment.

Strength of Evidence – Moderately Recommended, Evidence (B)

Level of Confidence – Moderate

Indications: Moderate to severe peripheral neuropathic pain that includes superficial pain generation (e.g., postherpetic neuralgia), peripheral nerve injury, and possibly some toxic neuropathies with superficial pain generation [1190-1192]. One quality trial [1193] evaluated treatment of CTS with pain as a central complaint when other treatable causes of the pain have been eliminated and after more efficacious treatment strategies, such as splinting and glucocorticosteroid injection(s), have been attempted.

Benefits: Modest improvements in pain

Harms: Dermal irritation and intolerance; may have adverse systemic effects if widespread applications of numerous patches

Frequency/Dose/Duration: Lidocaine patch 5%, up to 4 patches applied up to 12 hrs/day. Duration of use may be ongoing for chronic, localized pain, although most patients do not require indefinite treatment. Caution is warranted regarding widespread use of topical anesthetics for potential systemic effects from widespread administration.[221] Topical 5% lidocaine medicated plaster has also been used [1194-1197], as well as lidocaine spray [1198]

Indications for Discontinuation: Resolution, intolerance, adverse effects, lack of benefits, or failure to progress over a trial of at least 2 weeks.

Rationale: Lidocaine patches have been reportedly effective for treatment of localized peripheral neuropathic pain [1190-1192]. Topical lidocaine has been suggested to improve pain associated with CTS and appears to be somewhat more effective than naproxen.[222] This provides some basis for a consensus recommendation for treatment of peripheral neuropathic pain. Lidocaine patches are not invasive, generally have a low adverse effect profile, are moderately costly, have some evidence of efficacy for treatment of carpal tunnel syndrome and thus are recommended for treatment of peripheral neuropathic pain. It is not recommended for central neuropathic pain.

Evidence: A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Google Scholar without date limits using the following terms: neuropathic pain, nerve pain, neuralgia; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1413 articles in PubMed, 917 in Scopus, 176 in CINAHL, 9,630 in Google Scholar and 0 from other sources. We considered for inclusion 349 from PubMed, 0 from Scopus, 12 from CINAHL, 0 from Google Scholar and 0 from other sources. Of the 361 articles considered for inclusion, 238 randomized controlled trials and 123 systematic reviews met the inclusion criteria. A comprehensive literature search since 2012 was conducted using PubMed using the following terms: diabetic neuropathy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2423 articles in PubMed and 0 from other sources. We considered for inclusion 19 from PubMed and 0 from other sources. Of the 19 articles considered for inclusion, 13 randomized controlled trials and 0 systematic reviews met the inclusion criteria. There is one high-quality study and moderate-quality studies incorporated into this analysis.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters

because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:

Kweller, Esq., Zachary : 12/01/2021

Castro, Mario : 12/01/2021

UR, Chubb : 12/01/2021

Kweller, Esq., Zachary : 11/24/2021

Castro, Mario : 11/24/2021

This visit note has been electronically signed off by Jamasbi, Babak J., M.D. on 11/24/2021

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

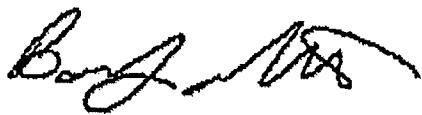
Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

<input checked="" type="checkbox"/> New Request <input type="checkbox"/> Resubmission – Change in Material Facts				
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health				
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.				
Employee Information				
Name (Last, First, Middle): Shockley, Jonathan				
Date of Injury (MM/DD/YYYY): 02/15/2019			Date of Birth (MM/DD/YYYY): 09/27/1978	
Claim Number: 040519008736			Employer: Biotelemetry, Inc	
Requesting Physician Information				
Name: Dr. Jamasbi, Babak J,				
Practice Name: PRCMG			Contact Name: Michelle for Xiena Z.	
Address: 1335 Stanford Ave			City: Emeryville	State: CA
Zip Code: 94608	Phone: 510-647-5101 x133		Fax Number: 510-647-5105	
Specialty: Pain Management			NPI Number: 1376637199	
E-mail Address:				
Claims Administrator Information				
Company Name: Chubb Son of Federal Ins Company			Contact Name: Castro, Mario	
Address: P.O. Box 42065			City: Phoenix	State: AZ
Zip Code: 85080	Phone: 213-612-5378		Fax Number: 800-664-1765	
E-mail Address:				
Requested Treatment (see instructions for guidance, attached additional pages if necessary):				
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.				
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Cervical disc disorder with radiculopathy, unspecified cervical region Other soft tissue disorders related to use, overuse and pressure, right upper arm Other soft tissue disorders related to use, overuse and pressure, left upper arm Other soft tissue disorders related to use, overuse and pressure, right forearm Lesion of ulnar nerve, unspecified upper limb	M70.832, M70.831, M70.822, M70.821, Z79.899, M50.10, G56.20, Z99.9	6 sessions of Chiropractic Treatment for the Neck, bilateral elbows, forearms, wrists and hands.	98941, 97140, G0283, 97012	

Treatment must be paid under the California OMFS

Peer to Peer calls: Mon-Friday:3:30pm -5pm PT. Please call (510) 647-5101 x0

040519008736

		Date: 12/01/2021 at 09:48 AM(PT)
Requesting Physician Signature:		
Claims Administrator/Utilization Review Organization (URO) Response		
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay)		
<input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)		
Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

DWC Form RFA (Effective 2/2014)

Page 1

CC:**UR Department (if applicable):**213-612-5785**Applicant Attorney (if applicable):**Zachary Kweiler, Esq. 866-819-6169**Nurse Case Manager (if applicable):**

040519008736



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Performing: Julia Fellows, PA-C

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Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.

Injury Date: 02/15/2019

Employer: Biotelemetry, Inc

Case Insurance: Chubb Son of Federal Ins Company

Claim No.: 040519008736

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Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

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Patient: Shockley, Jonathan DOB: 09/27/1978 Visit: 11/23/2021 Page: 1

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The patient is not married.

The patient has a significant other.

The patient has no children.

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Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

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4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

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PRESCRIPTION:**Refill Added:**

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TREATMENT PLAN:

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The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to assess his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presence of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presence of ulnar neuropathy.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied by IMR. Patient has nearly completed chiropractic therapy with benefit as described above. We will submit for 6 more today.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left

paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. He met with Dr. Solsar to discuss his neck and upper extremity symptoms. Per this report, Dr. Slosar does not find him to be a surgical candidate as cervical spine surgery will likely not lead to improvement of his upper extremity pain. The patient understands this.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had an abnormal TSH shortly after discontinuing gabapentin and he believes that the medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

-Patient currently defers the Functional Restoration Program.

-Patient saw Dr. Stoller again on 3/11/21 and we finally received this report. Per Dr. Stoller, the patient is permanent and stationary with 20% WPI and permanent disability. He did provision for future medical care as well. As patient currently defers FRP or further invasive care, we agree that he is MMI and have updated this below.

Follow up in 4-6 weeks.

WORK STATUS:

The patient is permanent and stationary per Dr. Stoller QME DOS 3/11/21.

TIME SPENT:

For this visit the total time the provider spent for the encounter is the most appropriate determinate of the level of service. The time reported includes the direct face to face time with patient and the total time spent 20 minutes.

This includes: counseling and educating the patient, family or caregiver, documenting clinical information in the electronic health record ordering medications, tests or procedures To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical

treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a

decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidoderm Patch: The following has been recommended regarding Lidoderm Patch in the MTUS/ACOEM guidelines

Lidocaine Patches for Neuropathic Pain
Moderately Recommended.

Lidocaine patches are moderately recommended for treatment of postherpetic neuralgia when there is localized pain amenable to topical treatment.

Strength of Evidence – Moderately Recommended, Evidence (B)

Level of Confidence – Moderate

Indications: Moderate to severe peripheral neuropathic pain that includes superficial pain generation (e.g., postherpetic neuralgia), peripheral nerve injury, and possibly some toxic neuropathies with superficial pain generation [1190-1192]. One quality trial [1193] evaluated treatment of CTS with pain as a central complaint when other treatable causes of the pain have been eliminated and after more efficacious treatment strategies, such as splinting and

glucocorticosteroid injection(s), have been attempted.

Benefits: Modest improvements in pain

Harms: Dermal irritation and intolerance; may have adverse systemic effects if widespread applications of numerous patches

Frequency/Dose/Duration: Lidocaine patch 5%, up to 4 patches applied up to 12 hrs/day. Duration of use may be ongoing for chronic, localized pain, although most patients do not require indefinite treatment. Caution is warranted regarding widespread use of topical anesthetics for potential systemic effects from widespread administration.[221] Topical 5% lidocaine medicated plaster has also been used [1194-1197], as well as lidocaine spray [1198]

Indications for Discontinuation: Resolution, intolerance, adverse effects, lack of benefits, or failure to progress over a trial of at least 2 weeks.

Rationale: Lidocaine patches have been reportedly effective for treatment of localized peripheral neuropathic pain [1190-1192]. Topical lidocaine has been suggested to improve pain associated with CTS and appears to be somewhat more effective than naproxen.[222] This provides some basis for a consensus recommendation for treatment of peripheral neuropathic pain. Lidocaine patches are not invasive, generally have a low adverse effect profile, are moderately costly, have some evidence of efficacy for treatment of carpal tunnel syndrome and thus are recommended for treatment of peripheral neuropathic pain. It is not recommended for central neuropathic pain.

Evidence: A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Google Scholar without date limits using the following terms: neuropathic pain, nerve pain, neuralgia; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1413 articles in PubMed, 917 in Scopus, 176 in CINAHL, 9,630 in Google Scholar and 0 from other sources. We considered for inclusion 349 from PubMed, 0 from Scopus, 12 from CINAHL, 0 from Google Scholar and 0 from other sources. Of the 361 articles considered for inclusion, 238 randomized controlled trials and 123 systematic reviews met the inclusion criteria. A comprehensive literature search since 2012 was conducted using PubMed using the following terms: diabetic neuropathy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2423 articles in PubMed and 0 from other sources. We considered for inclusion 19 from PubMed and 0 from other sources. Of the 19 articles considered for inclusion, 13 randomized controlled trials and 0 systematic reviews met the inclusion criteria. There is one high-quality study and moderate-quality studies incorporated into this analysis.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating

physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:

Kweller, Esq., Zachary : 12/01/2021

Castro, Mario : 12/01/2021

UR, Chubb : 12/01/2021

Kweller, Esq., Zachary : 11/24/2021

Castro, Mario : 11/24/2021

This visit note has been electronically signed off by Jamashi, Babak J., M.D. on 11/24/2021

Pain and Rehabilitative Consultants Medical Group

1335 Stanford Avenue

Emeryville, CA 94608

Telephone (510) 647-5101 • Fax (510) 647-5105

Name Jonathan Shockley 09/27/1978 Date 12/01/2021Address 1000 Sutter St Room 123 San Francisco, CA 94109

Rx 6 sessions of Chiropractic Treatment for the Neck, bilateral elbows, forearms, wrists and hands.

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm

M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm

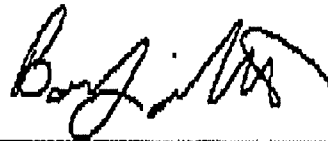
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm

M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region

G56.20 Lesion of ulnar nerve, unspecified upper limb

Refill


☐ Do Not Substitute
M.D.

☐ Mark Phillips, P.A.
DEA#: MP0998558 / LIC#: PA17702

☒ Babak Jamasbi, M.D.
DEA#: BJ2563345 / LIC#: G70042
DEA#: XJ2563345

☐ Timothy Lo, M.D.
DEA#: FL0167901 / LIC#: A92580
DEA#: XL0167901

☐ Brendan Morley, M.D.
DEA#: BM3191133 / LIC#: G74102
DEA#: XM3191133

☐ Arzhang Zerehschi, M.D.
DEA#: FZ3404477 / LIC#: A119704

☐ Neil K. Kamdar, M.D.
DEA#: FK5223172 / LIC#: A144608

☐ John W. Alchemy, M.D.
DEA#: BP4661369 / LIC#: A55085

☐ Filip F. Cheng, D.O.
DEA#: FC9695353 / LIC#: 20A18435

☐ Susie Paik, P.A.-C
DEA#: MP1537856 / LIC#: PA19005

☐ Donny J. Cho, P.A.-C
DEA#: MC2432386 / LIC#: PA21642

☐ Julia M. Fellows, P.A.-C
DEA#: MF4602288 / LIC#: 55158

☐ Giulia Ferrara, P.A.
DEA#: MF5991597 / LIC#: PA58278

☐ Binwant Singh, FNP
DEA#: MS5900623 / LIC#: 95014435

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

<input checked="" type="checkbox"/> New Request	<input type="checkbox"/> Resubmission – Change in Material Facts
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health	
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.	

Employee Information

Name (Last, First, Middle): Shockley, Jonathan	
Date of Injury (MM/DD/YYYY): 02/15/2019	Date of Birth (MM/DD/YYYY): 09/27/1978
Claim Number: 040519008736	Employer: Biotelemetry, Inc

Requesting Physician Information

Name: Dr. Jamasbi, Babak J,		
Practice Name: PRCMG	Contact Name: Michelle for Xiena Z.	
Address: 1335 Stanford Ave	City: Emeryville	State: CA
Zip Code: 94608	Phone: 510-647-5101 x133	Fax Number: 510-647-5105
Specialty: Pain Management	NPI Number: 1376637199	

E-mail Address:

Claims Administrator Information

Company Name: Chubb Son of Federal Ins Company		Contact Name: Castro, Mario	
Address: P.O. Box 42065		City: Phoenix	State: AZ
Zip Code: 85080	Phone: 213-612-5378	Fax Number: 800-664-1765	

E-mail Address:

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

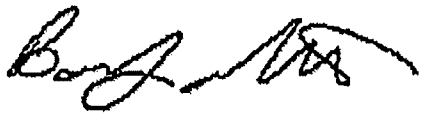
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Cervical disc disorder with radiculopathy, unspecified cervical region Other soft tissue disorders related to use, overuse and pressure, right upper arm Other soft tissue disorders related to use, overuse and pressure, left upper arm Other soft tissue disorders related to use, overuse and pressure, right forearm Lesion of ulnar nerve, unspecified upper limb	M70.832, M70.831, M70.822, M70.821, Z79.899, M50.10, G56.20, Z99.9	6 sessions of Chiropractic Treatment for the Neck, bilateral elbows, forearms, wrists and hands.	98941, 97140, G0283, 97012	

Treatment must be paid under the California OMFS

Peer to Peer calls: Mon-Friday:3:30pm -5pm PT. Please call (510) 647-5101 x0

040519008736

		Date: 12/01/2021 at 09:48 AM(PT)
Requesting Physician Signature:		
Claims Administrator/Utilization Review Organization (URO) Response:		
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay) <input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)		
Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

DWC Form RFA (Effective 2/2014)

Page 1

CC:

UR Department (if applicable):213-612-5785

Applicant Attorney (if applicable):Zachary Kweiler, Esq. 866-819-6169

Nurse Case Manager (if applicable):

040519008736



Pain & Rehabilitative CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshti, MD | Neil Kamdar, MD | John Alchemy, MD | Filip Cheng, DO

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:

Supervising: Babak J. Jamasbi, M.D.

Performing: Julia Fellows, PA-C

Encounter Date: Nov 23, 2021

Patient: Shockley, Jonathan (PT00023609)

Sex: Male

DOB: Sep 27, 1978 Age: 43 Year

Race: Unreported/Refused to Report

Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H):
415-312-4029

Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.

Injury Date: 02/15/2019

Employer: Biotelemetry, Inc

Case Insurance: Chubb Son of Federal Ins Company

Claim No.: 040519008736

VISIT TYPE:**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:**

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:

Patient is presents via Facetime to follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. He was approved to a consult and met with Dr. Slosar on 2/4/21. He is not currently a surgical candidate for the neck. He currently defers injection therapy as well.

Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied by IMR. He has completed 17/18 sessions of chiropractic therapy with benefit. He notes that these sessions helped to decrease his pain by about 30% and noted some improved tolerance for activity. He would like to continue if possible. He also trialed physical therapy but was only able to complete 1-2 sessions before his pain increased. He has discontinued this.

With regard to medication, he continues with Lidocaine crean, voltaren gel & Flector patches as topical medications. These decrease his pain from 5/10 to 2/10 and prevents flare ups. He denies side effects with his medications. He does request for refills today.

Patient reports seeing his QME in March 2021 and we have this report for review today.

Medical History:

PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY

The patient does not smoke cigarettes.

The patient does not drink alcoholic beverages.

The patient does not use illicit drugs.

The patient is not married.

The patient has a significant other.

The patient has no children.

Patient does not have a family history of childhood abuse.

Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:

*** FAMILY HISTORY

Patient does not have a family history of drug addiction.

Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:**2014 E/M:****Constitutional - General Appearance:**

Patient is near ideal body weight and is well groomed..

Orientation:

Patient is alert and oriented x3..

Mood and Affect:

Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:

1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply 2-3 grams to affected area up to 4 times daily update sig
3. Flector 1.3% Patch Apply 1 patch to affected area 12hours on/off
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:

and 6 sessions of Chiropractic Treatment 98941, 97140, G0283, 97012. Neck, bilateral elbows, forearms, wrists and hands.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:Refill Added:

1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1

2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 100.00. REF: 1

3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to assess his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presence of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presence of ulnar neuropathy.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied by IMR. Patient has nearly completed chiropractic therapy with benefit as described above. We will submit for 6 more today.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left

paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. He met with Dr. Solsar to discuss his neck and upper extremity symptoms. Per this report, Dr. Slosar does not find him to be a surgical candidate as cervical spine surgery will likely not lead to improvement of his upper extremity pain. The patient understands this.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had an abnormal TSH shortly after discontinuing gabapentin and he believes that the medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

-Patient currently defers the Functional Restoration Program.

-Patient saw Dr. Stoller again on 3/11/21 and we finally received this report. Per Dr. Stoller, the patient is permanent and stationary with 20% WPI and permanent disability. He did provision for future medical care as well. As patient currently defers FRP or further invasive care, we agree that he is MMI and have updated this below.

Follow up in 4-6 weeks.

WORK STATUS:

The patient is permanent and stationary per Dr. Stoller QME DOS 3/11/21.

TIME SPENT:

For this visit the total time the provider spent for the encounter is the most appropriate determinate of the level of service. The time reported includes the direct face to face time with patient and the total time spent 20 minutes.

This includes: counseling and educating the patient, family or caregiver, documenting clinical information in the electronic health record ordering medications, tests or procedures To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical

treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a

decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.

*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidoderm Patch: The following has been recommended regarding Lidoderm Patch in the MTUS/ACOEM guidelines

Lidocaine Patches for Neuropathic Pain
Moderately Recommended.

Lidocaine patches are moderately recommended for treatment of postherpetic neuralgia when there is localized pain amenable to topical treatment.

Strength of Evidence – Moderately Recommended, Evidence (B)

Level of Confidence – Moderate

Indications: Moderate to severe peripheral neuropathic pain that includes superficial pain generation (e.g., postherpetic neuralgia), peripheral nerve injury, and possibly some toxic neuropathies with superficial pain generation [1190-1192]. One quality trial [1193] evaluated treatment of CTS with pain as a central complaint when other treatable causes of the pain have been eliminated and after more efficacious treatment strategies, such as splinting and

glucocorticosteroid injection(s), have been attempted.

Benefits: Modest improvements in pain

Harms: Dermal irritation and intolerance; may have adverse systemic effects if widespread applications of numerous patches

Frequency/Dose/Duration: Lidocaine patch 5%, up to 4 patches applied up to 12 hrs/day. Duration of use may be ongoing for chronic, localized pain, although most patients do not require indefinite treatment. Caution is warranted regarding widespread use of topical anesthetics for potential systemic effects from widespread administration.[221] Topical 5% lidocaine medicated plaster has also been used [1194-1197], as well as lidocaine spray [1198]

Indications for Discontinuation: Resolution, intolerance, adverse effects, lack of benefits, or failure to progress over a trial of at least 2 weeks.

Rationale: Lidocaine patches have been reportedly effective for treatment of localized peripheral neuropathic pain [1190-1192]. Topical lidocaine has been suggested to improve pain associated with CTS and appears to be somewhat more effective than naproxen.[222] This provides some basis for a consensus recommendation for treatment of peripheral neuropathic pain. Lidocaine patches are not invasive, generally have a low adverse effect profile, are moderately costly, have some evidence of efficacy for treatment of carpal tunnel syndrome and thus are recommended for treatment of peripheral neuropathic pain. It is not recommended for central neuropathic pain.

Evidence: A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Google Scholar without date limits using the following terms: neuropathic pain, nerve pain, neuralgia; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1413 articles in PubMed, 917 in Scopus, 176 in CINAHL, 9,630 in Google Scholar and 0 from other sources. We considered for inclusion 349 from PubMed, 0 from Scopus, 12 from CINAHL, 0 from Google Scholar and 0 from other sources. Of the 361 articles considered for inclusion, 238 randomized controlled trials and 123 systematic reviews met the inclusion criteria. A comprehensive literature search since 2012 was conducted using PubMed using the following terms: diabetic neuropathy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2423 articles in PubMed and 0 from other sources. We considered for inclusion 19 from PubMed and 0 from other sources. Of the 19 articles considered for inclusion, 13 randomized controlled trials and 0 systematic reviews met the inclusion criteria. There is one high-quality study and moderate-quality studies incorporated into this analysis.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating

physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:

Kweller, Esq., Zachary : 12/01/2021

Castro, Mario : 12/01/2021

UR, Chubb : 12/01/2021

Kweller, Esq., Zachary : 11/24/2021

Castro, Mario : 11/24/2021

This visit note has been electronically signed off by Jamasbi, Babak J., M.D. on 11/24/2021

Pain and Rehabilitative Consultants Medical Group

1335 Stanford Avenue

Emeryville, CA 94608

Telephone (510) 647-5101 • Fax (510) 647-5105

Name Jonathan Shockley 09/27/1978 Date 12/01/2021Address 1000 Sutter St Room 123 San Francisco, CA 94109

Rx 6 sessions of Chiropractic Treatment for the Neck, bilateral elbows, forearms, wrists and hands.

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm

M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm

M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm

M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region

G56.20 Lesion of ulnar nerve, unspecified upper limb

Refill


☐ Do Not Substitute
M.D.

- ☐ Mark Phillips, P.A.
DEA#: MP0998558 / LIC#: PA17702
- ☒ Babak Jamasbi, M.D.
DEA#: BJ2563345 / LIC#: G70042
DEA#: XJ2563345
- ☐ Timothy Lo, M.D.
DEA#: FL0167901 / LIC#: A92580
DEA#: XL0167901
- ☐ Brendan Morley, M.D.
DEA#: BM3191133 / LIC#: G74102
DEA#: XM3191133

- ☐ Arzhang Zeresghi, M.D.
DEA#: FZ3404477 / LIC#: A119704
- ☐ Neil K. Kamdar, M.D.
DEA#: FK5223172 / LIC#: A144608
- ☐ John W. Alchemy, M.D.
DEA#: BP4661369 / LIC#: A55085
- ☐ Filip F. Cheng, D.O.
DEA#: FC9695353 / LIC#: 20A18435
- ☐ Susie Paik, P.A.-C
DEA#: MP1537856 / LIC#: PA19005


- ☐ Donny J. Cho, P.A.-C
DEA#: MC2432386 / LIC#: PA21642
- ☐ Julia M. Fellows, P.A.-C
DEA#: MF4602288 / LIC#: 55158
- ☐ Giulia Ferrara, P.A.
DEA#: MF5991597 / LIC#: PA58278
- ☐ Binwant Singh, FNP
DEA#: MS5900623 / LIC#: 95014435

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

<input checked="" type="checkbox"/> New Request <input type="checkbox"/> Resubmission – Change in Material Facts				
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health				
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.				
Employee Information				
Name (Last, First, Middle): Shockley, Jonathan				
Date of Injury (MM/DD/YYYY): 02/15/2019			Date of Birth (MM/DD/YYYY): 09/27/1978	
Claim Number: 040519008736			Employer: Biotelemetry, Inc	
Requesting Physician Information				
Name: Dr. Jamasbi, Babak J,				
Practice Name: PRCMG			Contact Name: Christian G.	
Address: 1335 Stanford Ave			City: Emeryville	State: CA
Zip Code: 94608	Phone: 510-647-5101 ext 471		Fax Number: 510-647-5105	
Specialty: Pain Management			NPI Number: 1376637199	
E-mail Address:				
Claims Administrator Information				
Company Name: Chubb Son of Federal Ins Company			Contact Name: Castro, Mario	
Address: P.O. Box 42065			City: Phoenix	State: AZ
Zip Code: 85080	Phone: 213-612-5378		Fax Number: 800-664-1765	
E-mail Address:				
Requested Treatment (see instructions for guidance attached additional pages if necessary)				
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.				
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Cervical disc disorder with radiculopathy, unspecified cervical region Other soft tissue disorders related to use, overuse and pressure, right upper arm Other soft tissue disorders related to use, overuse and pressure, left upper arm Other soft tissue disorders related to use, overuse and pressure, right forearm Lesion of ulnar nerve, unspecified	M70.832, M70.831, M70.822, M70.821, Z79.899, M50.10, G56.20, Z99.9	1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00 REF: 1 2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 100.00 REF: 1 3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12 hours on/off QTY: 30.00 REF: 1		

040519008736

upper limb		Date of Visit: Nov 23, 2021		
Treatment to be paid under the CA OMFS.				
Peer to Peer calls: Mon-Fri 3:30pm -5pm PT. Please call (510) 647-5101 x0				
Requesting Physician Signature: 			Date: 11/24/2021 at 01:59 PM(PT)	
Claims Administrator/Utilization Review Organization (URO) Response				
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay)				
<input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)				
Authorization Number (if assigned):			Date:	
Authorized Agent Name:			Signature:	
Phone:	Fax Number:		E-mail Address:	
Comments:				

CC:

UR Department (if applicable):213-612-5785

Applicant Attorney (if applicable):Zachary Kweiler, Esq. 866-819-6169



Pain & Rehabilitative CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshti, MD | Neil Kamdar, MD | John Alchemy, MD | Filip Cheng, DO

1335 Standford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:

Supervising: Babak J. Jamasbi, M.D.

Performing: Julia Fellows, PA-C

Encounter Date: Nov 23, 2021

Patient: Shockley, Jonathan (PT00023609)

Sex: Male

DOB: Sep 27, 1978 **Age:** 43 Year

Race: Unreported/Refused to Report

Address: 1000 Sutter St Room 123, San Francisco CA 94109 **Pref. Phone(H):**
415-312-4029

Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.

Injury Date: 02/15/2019

Employer: Biotelemetry, Inc

Case Insurance: Chubb Son of Federal Ins Company

Claim No.: 040519008736

VISIT TYPE:**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:**

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:

Patient is presents via Facetime to follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. He was approved to a consult and met with Dr. Slosar on 2/4/21. He is not currently a surgical candidate for the neck. He currently defers injection therapy as well.

Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied by IMR. He has completed 17/18 sessions of chiropractic therapy with benefit. He notes that these sessions helped to decrease his pain by about 30% and noted some improved tolerance for activity. He would like to continue if possible. He also trialed physical therapy but was only able to complete 1-2 sessions before his pain increased. He has discontinued this.

With regard to medication, he continues with Lidocaine cream, Voltaren gel & Flector patches as topical medications. These decrease his pain from 5/10 to 2/10 and prevents flare ups. He denies side effects with his medications. He does request for refills today.

Patient reports seeing his QME in March 2021 and we have this report for review today.

Medical History:

PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY

The patient does not smoke cigarettes.

The patient does not drink alcoholic beverages.

The patient does not use illicit drugs.

The patient is not married.

The patient has a significant other.

The patient has no children.

Patient does not have a family history of childhood abuse.

Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:

*** FAMILY HISTORY

Patient does not have a family history of drug addiction.

Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:**2014 E/M:****Constitutional - General Appearance:**

Patient is near ideal body weight and is well groomed..

Orientation:

Patient is alert and oriented x3..

Mood and Affect:

Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:

1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply 2-3 grams to affected area up to 4 times daily update sig
3. Flector 1.3% Patch Apply 1 patch to affected area 12hours on/off
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:

and 6 sessions of Chiropractic Treatment 98941, 97140, G0283, 97012. Neck, bilateral elbows, forearms, wrists and hands.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:Refill Added:

1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1

2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 100.00. REF: 1

3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to assess his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presence of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presence of ulnar neuropathy.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied by IMR. Patient has nearly completed chiropractic therapy with benefit as described above. We will submit for 6 more today.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left

paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. He met with Dr. Solsar to discuss his neck and upper extremity symptoms. Per this report, Dr. Slosar does not find him to be a surgical candidate as cervical spine surgery will likely not lead to improvement of his upper extremity pain. The patient understands this.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had an abnormal TSH shortly after discontinuing gabapentin and he believes that the medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

-Patient currently defers the Functional Restoration Program.

-Patient saw Dr. Stoller again on 3/11/21 and we finally received this report. Per Dr. Stoller, the patient is permanent and stationary with 20% WPI and permanent disability. He did provision for future medical care as well. As patient currently defers FRP or further invasive care, we agree that he is MMI and have updated this below.

Follow up in 4-6 weeks.

WORK STATUS:

The patient is permanent and stationary per Dr. Stoller QME DOS 3/11/21.

TIME SPENT:

For this visit the total time the provider spent for the encounter is the most appropriate determinate of the level of service. The time reported includes the direct face to face time with patient and the total time spent 20 minutes.

This includes: counseling and educating the patient, family or caregiver, documenting clinical information in the electronic health record ordering medications, tests or procedures To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical

treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a

decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.

*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidoderm Patch: The following has been recommended regarding Lidoderm Patch in the MTUS/ACOE guidelines

Lidocaine Patches for Neuropathic Pain
Moderately Recommended.

Lidocaine patches are moderately recommended for treatment of postherpetic neuralgia when there is localized pain amenable to topical treatment.

Strength of Evidence – Moderately Recommended, Evidence (B)

Level of Confidence – Moderate

Indications: Moderate to severe peripheral neuropathic pain that includes superficial pain generation (e.g., postherpetic neuralgia), peripheral nerve injury, and possibly some toxic neuropathies with superficial pain generation [1190-1192]. One quality trial [1193] evaluated treatment of CTS with pain as a central complaint when other treatable causes of the pain have been eliminated and after more efficacious treatment strategies, such as splinting and

glucocorticosteroid injection(s), have been attempted.

Benefits: Modest improvements in pain

Harms: Dermal irritation and intolerance; may have adverse systemic effects if widespread applications of numerous patches

Frequency/Dose/Duration: Lidocaine patch 5%, up to 4 patches applied up to 12 hrs/day. Duration of use may be ongoing for chronic, localized pain, although most patients do not require indefinite treatment. Caution is warranted regarding widespread use of topical anesthetics for potential systemic effects from widespread administration.[221] Topical 5% lidocaine medicated plaster has also been used [1194-1197], as well as lidocaine spray [1198]

Indications for Discontinuation: Resolution, intolerance, adverse effects, lack of benefits, or failure to progress over a trial of at least 2 weeks.

Rationale: Lidocaine patches have been reportedly effective for treatment of localized peripheral neuropathic pain [1190-1192]. Topical lidocaine has been suggested to improve pain associated with CTS and appears to be somewhat more effective than naproxen.[222] This provides some basis for a consensus recommendation for treatment of peripheral neuropathic pain. Lidocaine patches are not invasive, generally have a low adverse effect profile, are moderately costly, have some evidence of efficacy for treatment of carpal tunnel syndrome and thus are recommended for treatment of peripheral neuropathic pain. It is not recommended for central neuropathic pain.

Evidence: A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Google Scholar without date limits using the following terms: neuropathic pain, nerve pain, neuralgia; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1413 articles in PubMed, 917 in Scopus, 176 in CINAHL, 9,630 in Google Scholar and 0 from other sources. We considered for inclusion 349 from PubMed, 0 from Scopus, 12 from CINAHL, 0 from Google Scholar and 0 from other sources. Of the 361 articles considered for inclusion, 238 randomized controlled trials and 123 systematic reviews met the inclusion criteria. A comprehensive literature search since 2012 was conducted using PubMed using the following terms: diabetic neuropathy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2423 articles in PubMed and 0 from other sources. We considered for inclusion 19 from PubMed and 0 from other sources. Of the 19 articles considered for inclusion, 13 randomized controlled trials and 0 systematic reviews met the inclusion criteria. There is one high-quality study and moderate-quality studies incorporated into this analysis.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating

physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:

Kweller, Esq., Zachary : 11/24/2021

Castro, Mario : 11/24/2021

This visit note has been electronically signed off by Fellows, Julia, PA-C on 11/23/2021



Pain & Rehabilitative

CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshti, MD | Neil Kamdar, MD | John Alcheny, MD | Filip Cheng, DO

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:

Supervising: Babak J. Jamasbi, M.D.

Performing: Julia Fellows, PA-C

Encounter Date: Sep 30, 2021

Patient: Shockley, Jonathan (PT00023609)

Sex: Male

DOB: Sep 27, 1978 Age: 43 Year

Race: Unreported/Refused to Report

**Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H):
415-312-4029**

Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.

Injury Date: 02/15/2019

Employer: Biotelemetry, Inc

Case Insurance: Chubb Son of Federal Ins Company

Claim No.: 040519008736

VISIT TYPE:

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:

Patient is presents via Facetime to follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. He was approved to a consult and met with Dr. Slosar on 2/4/21. He is not currently a surgical candidate for the neck. He currently defers injection therapy as well.

Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied by IMR. He has completed 12/12 sessions of chiropractic therapy with benefit. He notes that these sessions helped to decrease his pain by about 30% and noted some improved tolerance for activity. He has been approved for 6 more and has been scheduled. He also trialed physical therapy but was only able to complete 1-2 sessions before his pain increased. He has discontinued this.

With regard to medication, he continues with Lidocaine crean, voltaren gel & Flector patches as topical medications. These decrease his pain from 5/10 to 2/10 and prevents flare ups. He denies side effects with his medications. He does request for refills today.

Patient reports seeing his QME in March 2021 and we have this report for review today.

Medical History:

PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY

The patient does not smoke cigarettes.

The patient does not drink alcoholic beverages.

The patient does not use illicit drugs.

The patient is not married.

The patient has a significant other.

The patient has no children.

Patient does not have a family history of childhood abuse.

Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:

*** FAMILY HISTORY

Patient does not have a family history of drug addiction.

Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:

2014 E/M:

Constitutional - General Appearance:

Patient is near ideal body weight and is well groomed..

Orientation:

Patient is alert and oriented x3..

Mood and Affect:

Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:

1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply 2-3 grams to affected area up to 4 times daily update sig
3. Flector 1.3% Patch Apply 1 patch to affected area 12hours on/off
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

- M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm

G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:

Refill Added:

1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1

2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 100.00. REF: 1

3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to assess his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presence of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presence of ulnar neuropathy.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied by IMR. Patient has completed chiropractic therapy with benefit as described above. He has been approved and scheduled for 6 more sessions.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. He met with Dr. Solsar to discuss his neck and upper extremity symptoms. Per this report, Dr. Solsar does not find him to be a surgical candidate as cervical

spine surgery will likely not lead to improvement of his upper extremity pain. The patient understands this.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had a abnormal TSH shortly after discontinuing gabapentin and he believe that he medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

-Patient currently defers the Functional Restoration Program.

-Patient saw Dr. Stoller again on 3/11/21 and we finally received this report. Per Dr. Stoller, the patient is permanent and stationary with 20% WPI and permanent disability. He did provision for future medical care as well. As patient currently defers FRP or further invasive care, we agree that he is MMI and have updated this below.

Follow up in 4-6 weeks.

WORK STATUS:

The patient is permanent and stationary per Dr. Stoller QME DOS 3/11/21.

TIME SPENT:

For this visit the total time the provider spent for the encounter is the most appropriate determinate of the level of service. The time reported includes the direct face to face time with patient and the total time spent 30 minutes.

This includes: counseling and educating the patient, family or caregiver, documenting clinical information in the electronic health record ordering medications, tests or procedures reviewing consultation or non-office based diagnostic test results, To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for

reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer

requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of

pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Lidoderm Patch: The following has been recommended regarding Lidoderm Patch in the MTUS/ACOEM guidelines

Lidocaine Patches for Neuropathic Pain
Moderately Recommended.

Lidocaine patches are moderately recommended for treatment of postherpetic neuralgia when there is localized pain amenable to topical treatment.

Strength of Evidence – Moderately Recommended, Evidence (B)

Level of Confidence – Moderate

Indications: Moderate to severe peripheral neuropathic pain that includes superficial pain generation (e.g., postherpetic neuralgia), peripheral nerve injury, and possibly some toxic neuropathies with superficial pain generation [1190-1192]. One quality trial [1193] evaluated treatment of CTS with pain as a central complaint when other treatable causes of the pain have been eliminated and after more efficacious treatment strategies, such as splinting and glucocorticosteroid injection(s), have been attempted.

Benefits: Modest improvements in pain

Harms: Dermal irritation and intolerance; may have adverse systemic effects if widespread applications of numerous patches

Frequency/Dose/Duration: Lidocaine patch 5%, up to 4 patches applied up to 12 hrs/day.

Duration of use may be ongoing for chronic, localized pain, although most patients do not require indefinite treatment. Caution is warranted regarding widespread use of topical anesthetics for potential systemic effects from widespread administration.[221] Topical 5% lidocaine medicated plaster has also been used [1194-1197], as well as lidocaine spray [1198]

Indications for Discontinuation: Resolution, intolerance, adverse effects, lack of benefits, or failure to progress over a trial of at least 2 weeks.

Rationale: Lidocaine patches have been reportedly effective for treatment of localized peripheral neuropathic pain [1190-1192]. Topical lidocaine has been suggested to improve pain associated with CTS and appears to be somewhat more effective than naproxen.[222] This provides some basis for a consensus recommendation for treatment of peripheral neuropathic pain. Lidocaine patches are not invasive, generally have a low adverse effect profile, are moderately costly, have some evidence of efficacy for treatment of carpal tunnel syndrome and thus are recommended for treatment of peripheral neuropathic pain. It is not recommended for central neuropathic pain.

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Followup:

6 Week(s)

CC:

Kweller, Esq., Zachary : 10/01/2021

Castro, Mario : 10/01/2021

This visit note has been electronically signed off by Jamasbi, Babak J., M.D. on 10/01/2021